

Early Draft
Unit 8

Classification of Health Care Providers

Summary

This document, being an early draft Unit for the SHA Manual revision, was presented and discussed at the OECD Health Accounts Expert meeting in Paris 7-8 October 2009. Your feedback, specifically on the questions raised at the end of this document with any other comments, is invited by 20 November 2009. Please send your comments to sha.contact@oecd.org

Author.....IHAT
Affiliation..... OECD-WHO-EUROSTAT
Submitted on 07-10-2009
Document codeSHA-REV 08300

*The opinions expressed and arguments employed herein do not necessarily reflect the official views of the **Organisation for Economic Co-operation and Development** or of the governments of its member countries, those of the **World Health Organization** or those of **EUROSTAT** or the **European Commission**.*

Classification of Health Care Providers

11th meeting of Health Accounts Experts and Correspondents for Health Expenditure Data, OECD Conference Centre, Paris

7-8 October 2009, including a joint session with Health Data Correspondents on the afternoon of 8 October

NOTE BY THE SECRETARIAT

1. Health Accounts methodological developmental work is a main component of the 2009-2010 OECD Programme of Work on Health. The aim of the methodological developmental work is to enhance the analytical power of the System of Health Accounts (SHA), improve the quality of the SHA as a statistical framework and provide better guidance for the application of the SHA by national statistical authorities. This work is planned to come together in the revision of the SHA Manual supervised by the International Health Accounts Team (IHAT) of Eurostat, OECD and WHO. This note sets out the proposed first IHAT draft of Unit 8 the classification of health care providers and has been prepared by Eurostat.

2. The ICHA-HP Classification of Health Care Providers has the following objectives:

- to offer a complete classification of health care providers,
- to structure the health care providers by their main characteristics, and
- to show the related structure of economic units, which support the processes and development of health care provision.

3. The structure mainly follows that of SHA1.0. The main changes proposed are:

(a) Households form a special class at the 1st digit level (HP*.5).

(b) Hospitals and nursing homes form a class of providers of inpatient care (HP*.1).

(c) Offices of other health practitioners and providers of home health care services have been combined.

(d) Providers of patient transportation are separated as special class.

(e) Provision and administration of public health programmes is integrated into HP*.6 “Providers of health administration and financing”. Additionally a special sub-class “Providers of preventive care” has been created (HP*.2.6)

(f) Providers of social care, education, research and development, and manufacturers of medical goods are classified under HP*.7 Other industries (rest of the economy) to make this part of the health care system more transparent and allow the consistent integration of additional modules.

4. Comments on this proposed first IHAT draft are invited at this meeting and/or later via email or to the SHA revision EDG. These will be taken into account when modifying this and preparing the next draft of Unit 3. Participating experts are invited to:

- COMMENT on the definitions and explanation of concepts presented in the paper;
- COMMENT on the changes proposed with respect to the current HP classification;
- REFLECT on and RESPOND to the specific questions raised by IHAT at the end of the paper.

TABLE OF CONTENTS

PREAMBLE.....	6
1. OVERVIEW.....	6
2. CONCEPT OF THE CLASSIFICATION OF HEALTH CARE PROVIDERS.....	8
2.1 Objectives.....	8
2.2 Economic units.....	8
2.3 Providers of health care (provision principal activity).....	14
2.4 Households.....	17
2.5 Providers of health administration and financing	18
2.6 Other Industries (rest of the economy).....	19
2.7. Further conceptual issues of ICHA-HP	19
3. EXPLANATORY NOTES TO THE ICHA-HP* CLASSIFICATION OF HEALTH CARE PROVIDERS (TO BE FURTHER DEVELOPED).....	22
3.1 Health care providers	22
3.2 Households.....	31
3.3 Health and financial administration	31
3.4 Other industries (Rest of the Economy).....	32
4. REFERENCES.....	38
QUESTIONS.....	40

Tables

Table 1. Classification of economic units in health accounts and health systems' dimensions.....	9
Table 2. Economic units of SHA and institutional sectors of SNA	12
Table 3. Draft classification of providers in SHA2.0 (Part I)	13

PREAMBLE

5. This draft outlines the ICHA-HP classification from the perspective of “economic units” in SHA. The idea is to improve the consistency of the accounts by the definition of the actors (consumers, providers, and financing units) as economic units. Together with the definition of health care functions¹ and the definition of financing units², the classifications shape the accounting space of the current health expenditure accounts. The tables HPxHC and HPxHF of the current expenditure account give a special view on the provision of services and the relation to providers (see units 3, 7, and 9). Complementary tables can be also built by this classification as it allows classification of all economic units of the economy.

1. OVERVIEW

6. Central issues of the discussion for the revision of ICHA-HP have been:
- The definition of the universe of health care providers, which is lacking in SHA1.0
 - The distinction between providers of health care and industries, which support health care providers
 - The distinction of ownership (public vs. private) and its economic characteristics (market vs. non-market)
 - The possible implementation of mode of production in the provider classification instead of in the functional classification of health care (unit 7).
7. The classification of health care providers serves the purpose to classify all economic units, which contribute to the provision of health care goods and services and by this the purpose of arranging country-specific /provider units into common, internationally applicable categories. In health care systems, economic units engaged in the provision of health care goods and services vary in their legal, accounting, organizational and operating structures. SHA1.0 has provided the international classification of health care

¹ Transactions in the core accounting framework of SHA take place between providers and consumers, providers and financing units, and financing units and consumers on markets or quasi markets. For further information about types of transactions see unit X.

² Accounts capture the transactions relevant to one stage or another of the process by which goods and services are produced and ultimately consumed.

providers (ICHA-HP), which was derived from NAICS³, but adapted for the purposes of health accounts. ICHA-HP*⁴ of SHA2.0 is broadly structuring provider entities into seven classes:

- Providers mainly delivering inpatient services (HP*.1 Hospitals and Long-term care nursing facilities)
- Providers mainly delivering ambulatory health care (HP*.2)
- Providers of patient transport (HP*.3)
- Retailers of medical goods for outpatients (HP*.4)
- Household as providers of home health care (HP*.5)
- Providers of health administration and financing (HP*.6)
- Other providers (HP*.7)
- Rest of the World (HP*.9).

8. HP*.1-HP*.4 are health care providers in the narrow sense that are fully recognized in each health care system. HP*.5 and HP*.6 are two special classes of providers. The former, households, are involved in all three type of activities (consumption, financing and provision), the latter providers of health administration and financing are of utmost importance for the managing health care system. HP*.7 contains providers of the rest of the economy. HP*.9 is reserved for providers outside the country.

9. Combining the ICHA-HP with ICHA-HC adds substantial richness to health expenditure information about the structure of health care delivery.⁵ In fact, the classification of health providers should help to answer the question: “What is the organisational structure, which is characteristic of the provision of health care within a country?” SHA1.0 has made the important step to distinguish between the type of service provided and the entity that provides it. This is very important and sometimes the source of some confusion that needs to be clarified. Health care services can often be provided in a wide range of settings. For example, outpatient treatment of an acute episode of a common infectious disease (such as malaria) may occur in clinics of community-based paramedical workers, in district-level health centres, in the offices of private physicians or in hospital outpatient departments. In this case, the type of service does not coincide with one specific type of provider. The range and types of health care provider units differ between countries. The aim of the health care provider classification is to capture these differences of country specific institutional arrangements rather than its international comparison. Therefore, it makes sense to distinguish between the HC-classification, which serves the purpose of international comparison, and the HP-classification which shows the variety of country specific settings of health provision.

³ North American Industry Classification System.

⁴ To avoid any confusion we add an asterisk * to the HP code if it is proposed for SHA2.0 (HP*).

⁵ The combination with Unit 13: Classification of Health Care Products would give further insight. This relation is here not considered.

2. CONCEPT OF THE CLASSIFICATION OF HEALTH CARE PROVIDERS

10. Although institutional structures of health care systems vary, health care providers should be comparable to some extent by their principal activities. But, finally, only the cross-classification of these characteristics (*e.g.* hospitals) with the functional classification HC makes comparisons possible.

2.1 Objectives

11. The main objectives of the classification of the HP health care providers are:

1. to present a complete classification of all health care providers
2. to structure the health care providers by their main characteristics, and
3. to show the related structure of economic units, which support the processes and development of health care delivery.

12. The HP classification has to structure the specialized units for health care provision into meaningful homogeneous groups within classes and heterogeneity between classes from international perspectives. Countries might deviate from this classification for national purposes in order to adapt better their national institutional arrangements.

13. The ICHA-HP Classification of Health Care Providers should be comprehensive and mutually exclusive. It should include all economic units in relation to the different dimensions of the health system.

2.2 Economic units

14. Economic units⁶ in SHA are centres of decision-making for transactions within the health system. Within the current health expenditure framework they decide about consumption, provision, and financing of health care services. In the complementary frameworks they may fulfil additional roles such as training of health personnel, supplying services to providers, research and development, and managing financial assets. Economic units are grouped according to their main activities into classes of providers. As economic units may perform several economic activities, it is important to acquire an overall picture about all economic units in the health system involved in different activities of health care delivery and financing. It is important to note that only households can perform all three types of activities: consumption, provision, and financing.⁷ Therefore, households are a unique class of economic units in the health system.

15. Table 1 provides an overview about the classification of economic units involved in different health systems' dimensions by their principal and secondary activities.

⁶ Please note economic units differ from institutional units defined in SNA which should keep a full set of accounts.

⁷ Households do also provide "sources" as defined in the Producers Guide. However, one might discuss whether "sources" can be a separate dimension of the system or is part of the function of "financing". Hernandez *et al.* (2007) distinguish four types of financial interventions: resource allocation, regulation, purchasing, pooling.

Table 1. Classification of economic units in health accounts and health systems' dimensions

Health dimensions*	Systems'	Economic Units / Institutional units			
		Providers HP*1-HP.4	Households HP*.5	Purchasing/ Financing units / Administration HP*6	Corporations (Rest of the economy) HP*7
1 Provision		Principal activity all types of health care	Home health care	Secondary activity	Secondary activity
2. CONSUMPTION			Principal activity		
3 Administration and management (Stewardship)		Secondary activity		Principal activity	(Principal activity)
4. Financing					
4.1 Co-financing		Co-financing	Cost-sharing		Co-financing
4.2 Resource allocation, purchasing, collecting, and pooling				Principal activity	
5. Provision related activities and non-health care activities		Secondary activity	Volunteering	Secondary activity	Principal activity or secondary activity provision related

* An additional dimension is resource generation as capital formation or education.

2.2.1 Criteria for classification of economic units in SHA

16. When classifying an economic unit the first question usually is: does the economic unit provide health care? Most countries keep registers of their health care providers because of the special conditions which these units must fulfil to provide quality health care. These registers are one of the main information sources. *Legal criteria* related to health knowledge that characterise the types of units are taken in the first step. The criteria *principal activity and secondary activity* are relevant in a second step when the providers are grouped into certain classes.⁸ In this context two exemptions exist:

- a) Households are classified as a special class (providers of home health care)
- b) Financing units are classified as a special class of providers of administrative services.

17. The reason for the last exemption is to keep consistency of the tri-axial system of the total amounts for transactions of HP, HC, and HF. It is necessary to separate the cost of administration including the administrative cost of health care financing (HP*.6).⁹

⁸ In SNA/ESA, the principal activity of a statistical unit is the activity which contributes most to the total value added of that unit. The principal activity is identified according to the top-down method and does not necessarily account for 50% or more of the unit's total value added. A secondary activity is any other activity of the unit, whose outputs are goods or services which are suitable for delivery to third parties. The value added of a secondary activity must be less than that of the principal activity.

⁹ The administrative cost of the economic units that manage the health care system has to be recorded separately and included independently of how health care financing is organised (tax based or insurance system) .

18. The classification of providers must be *comprehensive* and *mutual exclusive*. All economic units of an economy can provide some form of health care, which consequently means the classification of health care providers must be able to include all types of economic units. SHA1.0 has fulfilled this condition by the group HP.7 “Other industries (rest of the economy)”.¹⁰ SHA 2.0 follows this rule by giving more guidelines in that respect. *Mutual exclusiveness* means that an actor is counted only once in a group of economic units.

19. The classification of providers must take into account the particular *role of households in the provision of healthcare*. Households are different economic units as compared to the particular groups of providers of health care (HP*.1 - HP*.4). In a complementary health accounting framework special attention might be given to the health provision by individuals and therefore, households are classified in the HP-classification in SHA2.0 at 1st digit level.

20. *Financing units* are the second particular group of the current expenditure accounts of SHA, which must be distinguished from providers delivering health care services. From an analytical point of view financing units can fulfil both the purchasing of health care goods and services directly from providers and the insurance function (collecting premiums and pooling risks as well as to pay in the case of financial losses.¹¹) But, the transaction costs of this purchasing and insurance function are to be recorded separately as provision of administration.¹²

21. All economic units with health care outputs less than 50 % of their turnover have be classified under HP*.7 *Other industries*, except households and administrative units.¹³ Those with more than 50% turnover from health care activities have to be classified based on their principal health care activity and allocated into one of the HP* classes.¹⁴ A precondition for the grouping into principal and secondary providers is the ability to distinguish between activities and identify clear borderlines regarding what is inside and what is outside the health care boundary.

2.2.2 *Link with other classifications*

22. In the current expenditure accounts and the complementary accounts of SHA the HP-classification of health care providers must be able to link data

- on provision of health care goods and services with functions (HPxHC), see unit 7;
- on provision of health care goods and services and financing (HPxHF); see unit 9;
- on provision of health care goods and services with resources cost (HPxRC); see unit 12.

23. As a consequence, the classification of health care providers should be able to structure all economic units which provide health care either as principal activity or secondary activity as well as the rest of the economy.

¹⁰ See Jeong (2008) on the limits of the new category the Providers of health related function (M1(HP) introduced outside of the current provider classification into SHA Joint questionnaire in 2007..

¹¹ Other insurance functions are to prevent losses and to develop savings and investments against risks.

¹² To reach comparability the transaction cost of all financing functions (resource allocation, purchasing, pooling, collecting) should be included.

¹³ In SHA, the criterion is not the value added, but the share of expenditure as percent of turnover.

¹⁴ See also Liwendahl, Skygge 2008.

24. With respect to other statistical systems it has to be mentioned there is not a one to one relationship between HP* and ISIC / NACE. The latter classification is not detailed enough to classify the various health care providers. SHA1.0 is referring to the criteria of ISIC / NACE for the classification of health care providers.¹⁵ ICHA-HP provider classification is a refined and modified version of the health-relevant parts of the International Standard Industrial Classification, ISIC, Rev. 3 (United Nations, 1990), and more specifically of the North American Industry Classification System (NAICS).¹⁶ These two industry classifications define and delineate standard statistical units (whether as observation units or analytical units) based on certain criteria related to the production process.¹⁷

25. In ISIC, an industry consists of a group of establishments engaged in the same, or similar, kinds of activity. Activities in detail are captured by transactions in goods and services. The Central Product Classification provides the most comprehensive internationally agreed list of services (CPC/CPA)¹⁸ that is, unfortunately, not very detailed in health care. Occupation and professional education are criteria for the classification of activities in health care. The industry and product classification are not rigorously based on theoretical notions, e.g. the notion of a production function, which links inputs, technology, and outputs. This mainly reflects that a classification of economic units for statistical purposes should also be practical and balanced across different units.

26. There is (also) not a one to one relationship between the classes of HP* units and the institutional units of SNA.¹⁹ Table 2 exhibits the relation between the institutional sectors of SNA and the classes of economic units in the health care provider classification in SHA2.0. Institutional sectors of SNA are mutually exclusive subsets of the sets of institutions that form the economy. The classification of institutional sectors groups economic units on the basis of the type of organisation that is producing, e.g. a corporation, the government, or a household. In order to be able to link economic units of SHA2.0 with the institutional units of SNA it is necessary to reclassify economic units of SHA by the characteristics of SNA. However, the differences between the two systems have to be considered including inter alia:

¹⁵ The development of the classification of economic units HP in SHA2.0 was also guided by the main criteria driving the revision in ISIC/NACE: relevance to the actual world economy, better comparability with other national and international classifications, and continuity with their previous versions.

¹⁶ Mixed health care institutions, for example for institutional and ambulatory health care services, or integrated care units like community health centres do not easily fit into the ISIC. In SHA1.0, therefore, the North American Industry Classification System (NAICS) has been used as a starting point for classifying health care institutions.. NAICS is more strict and based on a single production-oriented concept. The boundaries between industries demarcate, in principle, differences in production processes and production technologies. (see *Statistics Canada* 2008). The ICHA-HP classification of SHA1.0 is essentially a modification of NAICS (SHA1.0: Table 4.1).

¹⁷ The criteria used by ISIC Rev.4 (see United Nations 2) are

- all categories at each level of the classification are mutually exclusive;
- the characteristics of outputs; and
- the use to which the outputs are put;
- similarity of the inputs of goods, services and factors of production; and
- similarity of the process and technology of production.

The importance of the interface of SHA to ISIC/NACE is not questioned here. We question only whether the fundamental rules for applying the institutional classification will be identical for both the ICHA-HP and ISIC (see SHA1.0).

¹⁸ In the development of the CPC, it is intended that each good or service distinguished in the CPC is defined in such a way that it is normally produced by only one activity as defined in ISIC.

¹⁹ In SNA/ESA two views are distinguished for the classification of economic units: the classification into institutional sectors and the classification into industries / branches. Both views are different from ICHA-HP.

- a) In SHA, consumers are at the same time providers of home health care, and
- b) financing units are providers of administration.

Table 2. Economic units of SHA and institutional sectors of SNA

Institutional sectors of SNA	Economic units of SHA 2.0			
	Health Care Providers HP.1-4	Households HP.5	Providers of health administration and financing HP.6	Other industries HP.7
Non-financial corporations (S.11)	Hospitals, providers of ambulatory care, pharmacies etc.			Private health care research institutes; Pharmaceutical, medical device industry, occupational care
Financial corporations (S.12)			Private insurance	Banks, Reinsurance
General government (S.13)	(Public hospitals, providers of ambulatory care) Preventive care units		Social insurance, government; Health administration	Public health care research institutes
Households (S.14)		Provision of home health care		
NPISHs (S.15)	Non profit hospitals, providers of ambulatory care, pharmacies etc.		Non-profit insurance	Social care providers

27. Health care providers in SHA2.0 are characterised by the country specific institutional structure of health care provision, independently of the activities that are defined by the functional classification in SHA. In SHA, the functional classification is defined by the purpose of the provision.²⁰ Behind the same purpose of provision, *e.g.* prevention, might be quite different technologies with different involvement of individuals and use of production factors. Often, health care providers provide both preventive and curative and rehabilitative services. It is of special interest to see how different providers provide these activities, what is in SHA applicable by crossing HPxHC, but the classification of health providers itself should be independent of the functional classification (HC).

2.2.3 Draft classification of providers in SHA2.0

28. Table 3 provides a classification of health care providers (HP*) and all economic units which support the processes and development of health care provision in SHA2.0. Main classes and sections will be explained in the following paragraphs.

²⁰ One might interpret the functional classification as classification of “products” of SHA.

Table 3. Draft classification of providers in SHA2.0 (Part I)

Type of economic unit	Providers			Financing units
	SHA2.0	SHA1.0	NACE Rev 2	SHA1.0
Hospitals and nursing care facilities	HP*.1.0			HF.2.5
Hospitals	HP*.1.1	HP.1.0		
General hospitals	HP*.1.1.1	HP.1.1	8610	
Specialised hospitals	HP*.1.1.2	HP.1.3	8610	
University hospitals	HP*.1.1.3	HP.1.1	8610	
Nursing care facilities	HP*.1.2	HP.2.1	8710	
Providers of ambulatory health care	HP*.2.0	HP.3		HF.2.5
Medical practice	HP*.2.1			
Offices of general medicine	HP*.2.1.1	HP.3.1	8621	
Offices of medical specialists	HP*.2.1.2	HP.3.1	8622	
Dental practice	HP*.2.2	HP.3.2	8623	
Other health practitioners	HP*.2.3	HP.3.3,3.6,3.9	8690, 88.1, 88.9	
Outpatient care centres	HP*.2.4			
Medical multi-specialized care centers	HP*.2.4.1	HP.3.4.5,3.4.9	8622	
Dialysis centres	HP*.2.4.2	HP.3.4.4	8690	
Community care centres	HP*.2.4.3	HP.3.4.9	8690	
Laboratories	HP*.2.5	HP.3.5, 3.9.2	8690	
Providers of preventive care	HP*.2.6	HP.5		
Providers of patient transportation	HP*.3.0	HP.3.9.1	8690	HF.2.5
Emergency ambulances	HP*.3.1	HP.3.9.1	8690	
Other specialised transportation in health care	HP*.3.2	HP.3.9.1	8690	
Retailers and other providers of medical goods	HP*.4.0	HP.4		HF.2.5
Pharmacies	HP*.4.1	HP.4.1	4773	
Retailers of vision products	HP*.4.2	HP.4.2	4778	
Retailers of hearing aids	HP*.4.3	HP.4.3	4774	
Other retailers of medical goods	HP*.4.9	HP.4.4,4.9	4774	
Households	HP*.5.0	HP.7.2	9820	HF.2.3
Providers of health administration and financing	HP*.6.0			HF.1
Government administrative units	HP*.6.1	HP.6.1	8412	HF.1.1
Social Insurance units	HP*.6.2	HP.6.2,6.3	8430	HF.1.2
Private Insurance units	HP*.6.3	HP.6.4	6512	HF.2.1, 2.2
NPISH	HP*.6.4	--	8899	HF.2.4
Other administrative units	HP*.6.9	HP.6.9		HF.2.5
Other Industries (rest of the economy)	HP*.7.0			HF.2.5
Social care providers	HP*.7.1	HP.2.2, HP.2.9		
Residential mental health care facilities	HP*.7.1.1	HP.2.2	8720	
Residential facilities for the elderly / disabled	HP*.7.1.2	HP.2.3	8730	
All other residential care facilities	HP*.7.1.3	HP.2.9	8790	
Other social care providers	HP*.7.1.9	HP.3.9, HP.7	88.1	
Education and Training	HP*.7.2			
Medical education and training	HP*.7.2.1		8540	
Other education and training	HP*.7.2.2		8500	
Research	HP*.7.3			
Scientific research	HP*.7.3.1		7200	
Market research	HP*.7.3.2		7320	
Industries	HP*.7.4			
Pharmaceutical Industry	HP*.7.4.1		2100, 2060	
Manufacture of medical supplies	HP*.7.4.2		3250	
Manufacture of denture	HP*.7.4.3	HP.4.4	3250	
Installation of medical equipment	HP*.7.4.4		3320	
Wholesale retailers of health care goods	HP*.7.5		4646	
Reinsurance of health insurance	HP*.7.6		6520	
Others	HP*.7.9			
Rest of the world	HP*.9.0	HP.9		HF.3

2.3 Providers of health care (provision principal activity)

29. The ICHA-HP classification of SHA2.0 is following the basic criteria defined already in SHA1.0 “ which means to include all economic units that are either engaged in the provision of health care services and goods (defined by ICHA-HC) and/or provision of health administration of financing”.. The criterion of external consistency with other statistical systems is of particular importance for the complementary modules in the production sphere of the health care system. Therefore, in SHA2.0, in the class HP*.1.-4. “Providers of health care” all institutions are included, which deliver services directly to patients (except households and providers of health administration and financing). Producers of specific goods and services which support health care provision are separately grouped in the HP*.7 "Other industries".²¹ Consequently, the ICHA-HP includes both principal and secondary providers of health care.^{22 23} But only producers with the principal activity of health care provision are called Health care providers, except households (HP*.5) and administrative units (HP*.6).

2.3.1 HP*.1 Hospitals and Nursing Care facilities

30. Hospitals provide the largest group of principal providers and a further sub-sectoring in general and specialised hospitals is proposed. Hospitals provide in-patient health services as primary activity. The activities of hospitals, carried out under the direct supervision of medical doctors and other health professionals, include:

- services of medical and paramedical staff
- services of laboratory and technical facilities, including radiological and anaesthetic services
- emergency room services
- provision of operating room services, pharmacy services, food and other hospital services
- other health services (services of family planning centres providing medical treatment such as sterilization and termination of pregnancy, with accommodation) ISIC 8610.

31. SHA1.0 distinguishes between general hospitals, psychiatric hospitals, and specialist hospitals (other than mental health and substance abuse hospitals). Results of the hospital expenditure data collection by the JHAQ in Europe show that most countries allocate hospital expenditures to general hospitals. The other two items are sometimes not compiled and therefore difficult to compare. Another split of hospital expenditures could be to distinguish between university and teaching hospitals on the side and general and specialised hospitals on the other side. This separation of university hospitals is also be useful for the compilation of expenditures for education and research, which are closely connected. However, ISIC Rev. 4/NACE Rev.2 do not further classify hospitals into subgroups.

²¹ In an extended framework, economic units / providers engaged also in the production and distribution, which support the activities of providers, are classified under HP*.7

²² For example, fire brigades, which provide rescue transport services as secondary activities. If there is no item for their principal activity then it is proposed that these secondary providers are classified as HP*.7 *Other institutions* (rest in the economy). The part of their activities related to the direct provision of health care (direct contact with patients) fall under the agreed health care boundary defined by the health care function.

²³ “For health satellite accounts, the production side of the economy can be divided into three kinds of activities: health care provider industries, other medical industries, other industries. Other medical industries are mainly acting as producers for intermediate consumption and for capital formation in the health care system, or for export. Part of final consumption in health care goods and services as well as part of intermediate products and gross capital formation is in turn imported” (SHA1.0: 8.21).

32. In the Producer Guide, a category has been added for hospitals of non-allopathic systems of medicine (PG: HP.1.4). This is an important category of providers in some countries, especially in South and East Asia. This category was introduced to capture expenditures for hospitals of medical systems such as Ayurveda or traditional Chinese medicine, which are not part of the regular allopathic systems of hospitals. In SHA 2.0 this type of hospital should be classified as specialised hospital HP*.1.1.2.

33. Providers of long-term nursing care have to consider the wide variation of institutional arrangements. This item comprises establishments primarily engaged in providing residential care combined with either nursing, supervisory or other types of care as required by the residents. In these establishments, a significant part of the care provided is a mix of health and social services with the health services being largely at the level of nursing services. The proposal for SHA2.0 is closely related to SHA1.0. Providers of long-term nursing care with dominant health care provision are classified, depending on mode provision, either under Nursing care facilities (HP*1.2), or under Community care centres (HP*.2.4.3), or as Other health practitioners, such as nurse practitioners -(HP*.2.3). Institutions with dominant social services are classified under HP*.7.1 Social care providers.

2.3.2 HP*.2 Providers of ambulatory health care

34. This item comprises establishments primarily engaged in providing medical care services directly to outpatients who do not require in-patient services. This item is made of six subcategories including:

- Medical practices HP*.2.1,
- Dental practices HP*.2.2,
- Other health practitioners HP*.2.3,
- Medical care centres HP*.2.4
- Laboratories HP*.2.5,
- Providers of preventive care HP*.2.6.

35. As most countries have implemented some form of primary care system, it would be functional to show explicitly primary care in health accounts. ISIC Rev. 4/NACE Rev.2 are supporting this by the separation between General medical practice 86.12 and specialist medical practice 86.22. Therefore, the HP*-Classification proposes a further breakdown at the 3-digit level. However, primary care is a wider concept than General medical practice and it can be only defined together with the functional classification of health expenditures.

36. A further proposal from (PG) is that the category for providers of all other ambulatory health care services (SHA1.0: HP.3.9.9) should include the wide variety of informal and less-than-fully-qualified health care providers operating in many low-income countries, regardless of whether these services are sanctioned by the legal system. HP*.2.3. *Other health practitioners* of SHA2.0 offers the possibility to include paramedical practitioners providing different forms of traditional medicine with a minimum of public control. The question is whether the further classification of this item should distinguish between those providers with special medical education and training (such as nurses, midwives, physiotherapists) and those without (such as traditional healers).²⁴

37. Integrated care refers usually to the vertical integration of activities along the treatment pathway, which means integration of different specialities as well as outpatient and inpatient treatment. It can be

²⁴ WHO Nairobi: Create a special subcategory (digit3) for independent traditional midwife under "other care providers".

classified under HP*2.3.1 *Medical Multi-specialised care centres*, or HP*2.4.3 *Community care centres*, or HP*.7.1.9 *Other social care providers*.²⁵ There is no clear definition across countries. To include it in the classification the criteria for its distinction should be provided. One viewpoint on integrated care is to close the traditional division between health and social care.²⁶ In the context of the classification of health care providers the organisational integration into single economic units is of interest – for example, the structural integration of primary, community and secondary care achieved by hospitals expanding their scope. In this case, either the classification as “hospital” or the classification as “ambulatory care unit” is misleading. There is a similarity to the “value chain” of SNA/ESA²⁷. It occurs where the different stages of production are carried out in succession by the same unit and where the output of one process serves as input to the next. Examples of common vertical integration include mammography screening, breast cancer surgery and treatment as well as rehabilitation, or pharmaceutical production and distribution. In health care, outpatient diagnostic of hospitals often serves for admission to inpatient departments. Vertically integrated units are difficult to classify because of their comprehensive services.²⁸ Costing information, if available, can be used to split up integrated care units into analytical economic units. But then the information about the national institutional structure is lost. Therefore, only by cross-classifications of institutional structures with functions and activities (single episodes of treatment or its sequence as a service package like DRG) give comparable information about the provision arrangements in certain settings.

38. In SHA1.0, the item ICHA-HP.5 Provision and administration of public health programmes comprises both government and private administration, and provision of health programmes such as health promotion and prevention programmes. It is proposed to separate these activities by distinguishing “Providers of preventive programs” (HP*.2.6) and Health program management by the Government. The former includes provision of preventive care for individual patients. The latter activity is part of the resource allocation, and as such recorded under providers of health administration and financing (HP*.6.1). The consequence of this solution would be that the total value of preventive care (both individual and collective) could be captured by the functional classification HC.

39. Similarly, in SHA2.0, the provision of occupational medicines (which was recorded under HP.5 in SHA1.0), would be recorded under providers of preventive programs (HP*2.6) if outsourced by

²⁵ In SHA1.0 HP. integrated care units are classified as 3.4.5 *all other outpatient multi-speciality and co-operative service centres*, and HP.3.4.9 *all other outpatient community and other integrated care centres*.

²⁶ The World Health Report 2003 proposed integrated care as one of the key pathways to improve primary care. In 2004, the European Commission declared integrated care as vital for the sustainability of social protection systems in Europe. Contandriopoulos 2001, Delnoij 2002 distinguish four different levels at which integration can occur:

- Functional integration occurs at the macro level of the care system, i.e. through the mainstreaming of the financing and regulation of cure, care, prevention, and social services.
- Organisational integration acts at the meso level of systems, e.g. in the form of mergers, contracting or strategic alliances between health and social care institutions.
- Professional integration is also at the meso level, e.g. in the form of mergers (e.g. group practices), contracting or strategic alliances between health care professionals.
- Clinical integration acts at the micro level, i.e. by providing continuity, co-operation and coherence in the primary process of care delivery – integration is thus at the individual level of care.

²⁷ A value chain is a chain of activities which add to products more value (added value).

²⁸ When a vertically integrated enterprise spans two or more sections of the ISIC, at least one establishment must be distinguished within each section.

enterprises to special medical providers, or to Other industries HP*2.6) if provided by enterprises in-house.
29

2.3.3 HP*.3 Providers of patient transportation

40. Transportation of patients might be carried out by different types of economic units. Transportation in specially-equipped vehicles or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care are often delivered by particular ambulance services such as the Red Cross. These specialised providers of transportation are listed under HP*.4. But, not all transportation is included under this item as transportation also includes transportation in conventional vehicles, such as taxis, when the latter is authorised and the costs are reimbursed to the patient (e.g. for patients undergoing renal dialysis or chemotherapy). In this case, the economic units are classified under HP*.7.9 Others.

2.3.4 HP*.4 Retailers and other providers of medical goods

41. The item “Retailers and other providers of medical goods” comprises specialized establishments whose primary activity is the retail sale of medical goods to the general public for personal or household consumption or utilisation. It is made up of four subcategories: pharmacies (HP*4.1), retailers of vision products (HP*4.2), retailers of hearing aids (HP*4.3), and other retailers of medical goods (HP*4.9).

2.4 Households

2.4.1 HP*.5 Households as providers of health care

42. Individuals as consumers of health care are living in households.³⁰ Only households can be engaged in all three functions: consumption, provision, and financing. Therefore, households have a unique position in health accounts.³¹ SHA2.0 gives a household a more prominent role under the item HP*.5.

43. The own-account provision of home health care services by members of the household for their own final consumption is excluded from measured production in conventional national accounting practice.³² In contrast to SNA, SHA explicitly recognises that the work devoted to the home care of household members has an economic value, which is measured in monetary terms. Cash allowances

²⁹ Following SHA1.0 preventive activities comprise establishments providing occupational health care, an ancillary activity within industry and administration, which in the case of industry is treated by SNA as intermediate consumption. An ancillary activity is a supporting activity undertaken within an enterprise in order to create the conditions within, which the principal or secondary activities can be carried out. All enterprises require some basic, routine services to support their production activities. When they are provided in house they are called ancillary activities (SNA2008: 5.3). In SNA, the output of the ancillary unit is treated as intermediate consumption of the establishments it serves and should be allocated across them using an appropriate indicator such as the output, value added or employment of these establishments.

³⁰ In SHA1.0 households are listed as providers under HP.7.2 providers of home care and as financing units under HF.2.3 Out-of pocket payment.

³¹ It is important to note that in SNA, the principal roles of households differ from SHA. Households are in SNA also employees and unincorporated producers..

³² In SNA, the provision of services by members of the household for their own final consumption has traditionally been excluded from measured production. One main reason is that labour force would include inactive household members if household production would be considered. Entries as care of sick, infirm or old people are not recorded in SNA when they are produced by household members and consumed within the same household:

granted to households for home health care, such as nursing allowance, is considered as “paid” household provision.³³ For the detailed guidelines on what is included and what not see unit 7.

2.5 Providers of health administration and financing

2.5.1 HP*.6 General administration and insurance

44. It is proposed that for consistency reasons this part of the classification should be closely linked to the accepted structure of the HF-Classification.³⁴ The item “Providers of health administration and financing” of SHA2.0 may comprise units with two types of activities (administration and financing) as in SHA1.0. The establishments primarily engaged in the regulation of activities of agencies that provide health care, overall administration of health policy are under (HP*.6.1). The different units of health insurance administration should be recorded under HP*.6.2 - HP*.6.4. In total, five subcategories are included in SHA2.0:

- HP*.6.1 Government administration of health
- HP*.6.2 Social security funds
- HP*.6.3 Private insurance units
- HP*.6.4 NPISH
- HP*.6.9 All other providers of health administration.

HP*.6.1 might be related to HP*2.6 Providers of preventive care (see proposal in paragraph 26).³⁵

45. Extra-budgetary units, such as social insurance, should be grouped under relevant items. According to IMF instructions extra-budgetary entities or units and social security units operate under the authority of the central government, but are not (fully) covered by the central government budget (“budgetary central government”). Typically, these units or entities have individual budgets, and their own-revenue sources may be supplemented by grants (transfers) from the budgetary central government or from other sources.

46. SHA1.0 has not developed the accounting of premiums and claims. In SHA 2.0, administration is a term used to cover the overhead costs of provision of insurance services. This includes the costs of activities such as ancillary services and personnel. SHA-Guidelines by ONS provide further information, which could be useful in adapting the manual, *e.g.* “A way to allocate expenditure on administration in health insurance companies will be to use the ‘service charge’ given by: Administration in health insurance companies = Service charge = Sum of all premiums – Sum of all payouts.” Profit and losses have to be considered (to be discussed in unit 12).

³³ However, not all countries have implemented this guideline because of difficulties to measure home health care provision. Home health care provision is actually not integrated in the Spanish, UK and the Swiss health accounts. According to a recent academic study in Switzerland, the costs of unpaid work for care to dependent persons can be estimated at 0.3% of GDP or nearly 3% of the total expenditure on health.

³⁴ see *van Mosseveld* 2009.

³⁵ As *Jeong* (2008) mentioned: Factors of both function and provider are mixed. “Provision and administration of public health programs” or “General health administration and insurance” are not names for providers, but for functions.

2.6 Other Industries (rest of the economy)

2.6.1 HP*.7 Other industries

47. Under this class of the HP*-classification all economic units are captured that cannot be classified by the characteristics of HP*.1 - HP*.6 (*e.g.* providers of health care which predominantly offer social care, providers of health education or providers of research). The improvement as compared to SHA 1.0 is that this class of the HP-classification is outlined in more detail (please see explanatory notes).

2.7. Further conceptual issues of ICHA-HP

48. There are further issues related to classification of health accounts which are important for the consistency of SHA as a whole. These are

- boundaries
- mode of production (inpatient, outpatient, others);
- ownership (private, non-for profit, public);
- market, non-market provision;
- renting and repair of medical equipment.

2.7.1 Boundary issues

49. The consumption boundary of SHA is defined by the functional classification. The classification of providers should be independent of the functional classification. However, there is also a need for comparison of institutional structures, *e.g.* hospitals. Therefore, all economic units which provide health care are classified in special classes. Providers are economic units that receive money in exchange for or in anticipation of providing the activities inside the health care accounts boundary that serve the purposes defined in the functional classification. Health services provision for final use in a country differs from the consumption by the resident population by the external trade in final health services and goods. It comprises the sum of services and goods consumed by individuals in order to secure or develop health through the application of medical, paramedical and nursing knowledge and technology plus the exported health provision minus the imported health services and goods for final use. Health goods and services are often provided for non-resident individuals. As a consequence, domestic provision of health care services differs from domestic consumption. For any balance of demand and supply by products or services of health providers exports (in products and in services of domestic providers for non-residents) have to be recorded (see Unit 3).

50. As discussed in Unit 2 *Boundary of the health accounts*, countries might be interested to expand the consumption boundary. This will lead to the consideration of additional activities of production and will give economic units more weight, which do not deliver health services. The intention of the complementary modules is to give countries some flexibility to include additional variables in a consistent way with the consumption framework as regarding health-related activities and supporting activities including investment outlays of health care providers.

2.7.2 Mode of Provision

51. In SHA1.0 mode of provision is a part of the functional classification ICHA-HC. The items HC.1 until HC.4 contain as fourth dimension of SHA, the “mode of production”. However, as a matter of consistency with the notion of the provider classification and the boundary of current expenditure account the reference to “mode of provision” is used. The basic subdivision into in-patient care, day care,

outpatient and home health care corresponds to an essential difference in the underlying technical and managerial organisation of care. As a result, these subsystems of care are typically governed by substantially different information systems. In-patient and day care involves the formal admission and discharge of patients involving a considerable amount of administrative paperwork and statistics. This has also led to the design in of basic standard datasets on patients and procedures they receive with the goal of making them comparable across economic units.

52. Mode of provision is a particular dimension of health care delivery. It is closer to the settings (inpatient, day care, outpatient, home care) and not to the function (purpose, output), *e.g.* cure or care.³⁶ Hospitals, integrated care units, and health centres provide services for inpatients and outpatients. In the provision process of health care, ancillary services as imaging or laboratory test play an important role and could be included into one of the modes of provision. In hospitals, imaging and laboratory test are provided in special departments. Although most countries might be able to provide costing information, a standardized concept is needed to deal with non-patient related activities within an institution. In order to analyse the provision process, it is crucial to select units, which illustrate technical/economic relationships (*i.e.* kind-of-activity units at local level and units of homogeneous production).³⁷

2.7.3 Public / private ownership

53. The ICHA-HP classification of SHA 2.0 does not distinguish between public or private ownership and the legal status of establishments. It is proposed that an additional breakdown, according to these dimensions, has to be decided on a case-by-case basis by Health Accountants. As the public /private ownerships breakdown has its value mainly for national analysis it is recommend to apply the criteria public / private ownership depending on the rules of SNA.³⁸ Subcategorising providers within the ICHA-HP by *type of ownership* might be useful for analytical purposes related to efficiency and quality of health care provision of public vs. private owners of health premises.

2.7.4 Market and non-market production

54. SNA makes a conceptual distinction between market, own final use and non-market goods and services, allowing in principle any kind of good or service to be any of these three types. In health care often quasi-markets exist where services are purchased based on complex pricing systems by DRGs. Any distinction between a market and non-market product depends therefore very much on the national system. It is recommended not to apply the criteria market/non-market production compulsorily in SHA.³⁹

2.7.5 Renting and repair of medical equipment

55. In some countries, renting, and repair of medical equipment, *e.g.* wheelchairs, is a normal part of the health care goods delivery process. In COICOP, renting and repair of therapeutic appliances and equipment is reported under the corresponding categories of goods. Also in SHA1.0 it is recommended to include the fitting and repair provided in combination with sales of prostheses, hearing aids, vision

³⁶ See also the proposal to introduce a special classification for settings *Roubal 2008* and *Schneider 1995* who distinguishes between activities, producing units, and technology..

³⁷ In order to analyse flows involving income, capital, financial transactions and assets, it is essential to select units which depict the interaction between economic transactions (institutional units).

³⁸ For a discussion of this issue see Kawiorska D. (EUROSTAT) and Quintela I. (Statistics Portugal): Draft Guidelines for the Delineation into Public and Private Units at: <http://www.oecd.org/dataoecd/38/14/40191715.pdf>.

³⁹ For a discussion of this issue see *Quintela 2007, National Board of Health 2008*.

products under the corresponding retailers of medical goods. However, under the class HP*.7 Other industries one might distinguish a special economic unit for repair (Repair of other machinery and equipment is classified in group 331 ISIC/NACE, Repair of buildings and other structures is classified in division 43 ISIC/NACE).

2.7.6 Data issues, statistical unit, and reporting unit

56. Country-specific listings of health care institutions are the starting point of grouping health care providers into ICHA-HP*. EUCOMP tried to support countries by a standardized tool. Full consistency would require that the national expenditure series were cross-classified with the ICHA-HP* institutional classification. Once a country-specific list of institutions and a cross-classification to the ICHA-HP* classification has been established, it should not be too difficult to identify the relevant data accordingly. The classification of the economic units should follow their principal activity in the HP* classification. If the unit performs several economic activities (other than ancillary activities,⁴⁰ the principal activity is determined on the basis of the expenditures/output associated with each activity (to be discussed), which is in contrast to the ISIC/NACE rules.⁴¹ For those providers which cannot be classified the Producer Guide has proposed the category (HP.nsk). If entities cannot be classified, they should be recorded under HP*.7.9 Others.

57. The reporting unit is the entity from which the recommended items of data are collected. It will vary between group of providers and from country to country, depending on institutional structures, the legal framework for data collection, traditions, national priorities and survey resources. It may be an enterprise of health care organisations on which information is received or a government unit. Often health care statistics are compiled or an analytical unit created by splitting or combining observation units with the help of estimations or imputations in order to supply more detailed and/or homogeneous data than would otherwise be possible. However, this process is often very burdensome, and it is therefore necessary to have strong links to existing statistical systems. It is recommended that the reporting unit on health care expenditure data be closely linked with non-expenditure data.

2.7.8 Resident units

58. A health care provider is said to be a resident unit of a country when this unit engages for a year or more in provision activities on the economic territory of the country. In SNA/ESA, the establishment is defined by the locality and type of production. Locality is not explicitly considered as a criterion in SHA, only the residence.

⁴⁰ An activity is ancillary if it fulfils all the following conditions: (a) it serves only the unit or units referred to; (b) the inputs contribute to the costs of the unit; (c) the outputs (usually services, seldom goods) are not part of the unit's final product and do not generate gross fixed capital formation; (d) a comparable activity on a similar scale is performed in similar production units; *Eurostat*, NACE Rev. 2 Introductory Guidelines.

⁴¹ Value added is the basic concept for determining the classification of a unit according to economic activities in SNA/ESA (see above).

3. EXPLANATORY NOTES TO THE ICHA-HP* CLASSIFICATION OF HEALTH CARE PROVIDERS (TO BE FURTHER DEVELOPED)⁴²

3.1 Health care providers

HP.1 Hospitals and residential care facilities*

HP.1.1 Hospitals*

59. This item comprises licensed establishments primarily engaged in providing medical, diagnostic, and treatment services that include physician, nursing, and other health services to in-patients and the specialised accommodation services required by in-patients. Hospitals may also provide out-patient services as a secondary activity. Hospitals provide in-patient health services, many of which can only be provided using the specialised facilities and equipment that form a significant and integral part of the production process. In some countries, health facilities need in addition a minimum size (such as number of beds) in order to be registered as a hospital.

HP*.1.1.1 General hospitals

60. This item comprises licensed establishments primarily engaged in providing diagnostic and medical treatment (both surgical and non-surgical) to in-patients with a wide variety of medical conditions. These establishments may provide other services, such as out-patient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services for a variety of procedures, and pharmacy services.

Illustrative examples

- general acute care hospitals;
- community, county, and regional hospitals (other than speciality hospitals);
- army, veterans, and police hospitals (other than speciality hospitals);
- prison hospitals.⁴³

61. *Note:* In contrast to SHA1.0 not included are integrated community care centres providing both in-patient and out-patient services but which are primarily engaged in in-patient services. Integrated community care centres providing both in-patient and out-patient services should be recorded under HP*.2.4.3. Furthermore, not included are university hospitals, which are covered by a separate item HP*.1.1.3.

HP*.1.1.2 Speciality hospitals

62. This item comprises licensed establishments primarily engaged in providing diagnostic and medical treatment to in-patients with a specific type of disease or medical condition (including mental

⁴² After approval of the HP-classification, the further development and explanations of provider categories will be developed consider both the detailed description and the linkage to ISCED and ISCO. Countries are invited to pay special attention to this part of the unit 8 in order to improve it by corrections and country examples.

⁴³ In the case of army or prison hospitals the criterion of principal activity might be violated.

health or substance abuse hospitals). Hospitals providing long-term care for the chronically ill and hospitals providing rehabilitation, and related services to physically challenged or disabled people are included in this item. These hospitals may provide other services, such as out-patient services, diagnostic X-ray services, clinical laboratory services, operating room services, physical therapy services, educational and vocational services, and psychological and social work services.

Illustrative examples

- specialised hospitals (oncology, gastroenterological, pediatric, orthopaedic, cardiology, etc);
- specialised emergency centres;
- speciality sanatoriums (primarily engaged in medical post-acute, rehabilitative and preventive services);
- oriental (traditional) medicine hospitals;
- special hospitals for infectious disease (tuberculosis hospitals; hospitals for tropical diseases).
- mental health and substance abuse hospitals

Cross-references

- establishments licensed as hospitals primarily engaged in providing diagnostic and therapeutic in-patient services for a variety of medical conditions, both surgical and non-surgical, are classified under HP*.1.1.1 General hospitals, (except university hospitals);
- establishments referred to as hospitals but primarily engaged in providing in-patient nursing and rehabilitative services to persons requiring convalescence are classified under HP*.1.2.1 Nursing care facilities;
- establishments primarily engaged in providing treatment of mental health and substance abuse illnesses on an out-patient basis are classified under HP*.2.4.3 *Community care centres*;
- establishments referred to as hospitals but primarily engaged in providing residential care of persons diagnosed with mental retardation, or establishments referred to as hospitals but primarily engaged in providing in-patient treatment for mental health and substance abuse illnesses with the emphasis on counselling rather than medical treatment are classified under HP*.7.1.1 *Residential mental care facilities*.

HP*.1.1.3 University hospitals

63. This item comprises licensed tertiary hospitals engaged in academic medical education, clinical research and patient care as teaching hospitals and university hospitals (other than speciality hospitals).

HP*.1.2 Nursing care facilities

64. This item comprises establishments primarily engaged in providing in-patient nursing and rehabilitative services. The care is generally provided for an extended period of time to individuals requiring nursing care. These establishments have a permanent core staff of registered or licensed practical nurses who, along with other staff, provide nursing and continuous personal care services. Medical nursing care facilities provide predominantly long-term care but also occasionally acute health care and nursing care in conjunction with accommodation and other types of social support such as assistance with day-to-day living tasks and assistance towards independent living.

65. The exact classification in the corresponding types of institutions (Nursing care facilities, Residential mental retardation, mental health and substance abuse facilities, Community care facilities for the elderly, Other residential care facilities) depends on the country-specific division of labour in the care process, especially in long-term care. As a general rule, all institutions should be listed, where a considerable share of all activities performed in that institution have a medical component or consist of nursing care with a strong medical component, usually performed by medical personnel acting as employees of the institution.

Illustrative examples

- convalescent homes or convalescent hospitals (other than mental health and substance abuse facilities);
- homes for the elderly with nursing care;
- in-patient care hospices;
- nursing homes;
- rest homes with nursing care;
- skilled nursing facilities (USA);
- teaching nursing homes.

Cross-references

66. Assisted-living facilities with on-site nursing care facilities are classified under HP*.7.1.9 Other social care providers. Institutions where medical interventions are more of an incidental character are classified under HP*.7.1 Social care providers. This should also apply to institutions with a physician acting as director of *e.g.* a home for handicapped persons, where medical and nursing care accounts for only a small share of the overall activity of that institution. Another example of institutions of this type is residential homes for the elderly with visiting nurses. Independent nurses visiting these institutions should be reported separately as a corresponding category of ambulatory care (HP*.2.3 Other health practitioner).

HP*.2 Providers of ambulatory medical care

67. This item comprises establishments primarily engaged in providing medical care services directly to out-patients. This includes establishments specialised in the treatment of day-cases and in the delivery of home health care services. Consequently, these establishments do not usually provide in-patient services. Health practitioners in ambulatory health care primarily provide services to patients visiting the health professional's office or visiting them at home.

HP*.2.1 Medical practice

68. This item comprises both offices of medical practitioners and medical specialists (other than dental practice) in which medical practitioners holding the degree of a doctor of medicine or a qualification at a corresponding level (ISCO-88 fourth degree level), primarily engaged in the independent practice of general or specialised medicine (including psychiatry, psychoanalysis, osteopathy, homeopathy) or surgery.

HP*.2.1.1 Offices of medical practitioners⁴⁴

⁴⁴ It needs a clarification whether expression "general medical practice" is used as in NACE 86.21 or "offices of medical practitioners" as preferred by France (see comment of M. Duee).

69. This item comprises establishments of health practitioners holding the degree of a doctor of medicine or a qualification at a corresponding level (ISCO-88 fourth degree level), primarily engaged in the independent practice of general medicine (including psychoanalysis, osteopathy, homeopathy). These practitioners operate private or group practices in their own offices (*e.g.* centres, clinics) or in the facilities of others, such as hospitals or health maintenance organizations (HMO) type medical centres.

Illustrative examples

- general practitioners in private offices;
- paediatricians in private offices;
- independent practising general practitioners and paediatricians within the public system.

Cross-references

- free-standing medical centres primarily engaged in providing emergency health care for accident or catastrophe victims and free-standing ambulatory surgical centres are classified under HP*.2.4 Outpatient care centres.

HP*.2.1.2 Offices of medical specialists

70. This class includes medical consultation and treatment in the field of specialised medicine by medical specialists and surgeons. This class also includes family planning centres providing medical treatment such as sterilisation and termination of pregnancy, without accommodation.

Illustrative examples

- Offices of surgeons,
- Offices gynaecologists,
- Offices of endocrinologists,
- Offices of ENT,
- Offices of gastroenterologists,
- Offices of infection specialists,
- Offices of nephrologists,
- Offices of orthopedists,
- Offices of pathologists,
- Offices of preventive medicine specialists,
- Offices of psychiatrist,
- Offices of radiologist, and radiotherapist,
- Offices of rheumatologists,
- etc.
- Establishments known as medical clinics, which are primarily engaged in the treatment of out-patients (Korea, Japan).

Cross-references

- to be developed

Note: This class excludes:

- Specialists providing as self-employed inpatient hospital activities in hospitals, see HP*.1.1.1 General hospitals.
- Offices of midwives, physiotherapists and other paramedical practitioners, see HP*.2.3 Other health practitioners.

HP.2.2 Offices of dentists / dental practice*

71. This item comprises establishments of health practitioners holding the degree of Doctor of dental medicine or a qualification at a corresponding level (ISCO-88 fourth degree level), primarily engaged in the independent practice of general or specialised dentistry or dental surgery. These practitioners operate private or group practices in their own offices (*e.g.* centres, clinics) or in the facilities of others, such as hospitals or HMO medical centres. They can provide dental practice activities of a general or specialised nature, *e.g.* dentistry, endodontic and pediatric dentistry; oral pathology and orthodontic activities

Cross-references

- dental laboratories primarily engaged in making dentures, artificial teeth, and orthodontic appliances for dentists are classified under HP*.7.4.3 *Manufacture of denture*;
- establishments of dental hygienists primarily engaged in cleaning teeth and gums or establishments of denturists primarily engaged in taking impressions for and fitting dentures are classified under HP*2.3.2 *Other health practitioners?*

*HP*2.3 Other health practitioners*

72. This item comprises the group of paramedical and other independent health practitioners (other than physicians, and dentists), such as chiropractors, optometrists, mental health specialists, physical, occupational, and speech therapists and audiologists establishments primarily engaged in providing care to out-patients. These practitioners operate private or group practices in their own offices (*e.g.* centres, clinics) or in the facilities of others, such as hospitals or HMO medical centres.

73. This item includes paramedical practitioners providing so-called “traditional medicine” without a doctor’s approbation. Some form of legal registration and licensing (implying a minimum of public control over the contents of care provided) is regarded as a necessary condition in order to be reported as paramedical practitioner in many countries. The item comprises furthermore establishments primarily engaged in providing skilled nursing services in their own offices or in patient’s home, along with a range of the following: personal care services; homemaker and companion services; physical therapy; medical social services; medications; medical equipment and supplies; counselling; 24-hour home care; occupation and vocational therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy.

Illustrative examples

- independent midwives;
- offices of nurses;
- community nurses and domiciliary nursing care (including child day-care in the case of sickness);
- home health care agencies;
- in-home hospice care services;
- visiting nurse associations;
- acupuncturists’ offices (other than physicians);

- chiropractors;
- physiotherapists and physical therapists;
- occupational and speech therapists;
- audiologists;
- dental hygienists' offices;
- denturists' offices;
- dieticians' offices;
- homeopaths' offices (other than physicians);
- inhalation or respiratory therapists' offices;
- naturopaths' offices (other than physicians);
- podiatrists' offices;
- practitioners of Chinese medicine and other forms of traditional medicine; formal licensing may not be required as criteria for recognition as health practitioner in countries where these forms of medicine have been an integral part of medical practice for a long time;
- oriental (traditional) medicine clinics (Korea).

Cross-references

- the independent practice of medicine and mental health by physicians is classified under HP*.2.1.1 Offices of medical practitioners, HP*.2.1.2 Offices of medical specialists;
- the independent practice of dentistry is classified under HP*.2.2 Offices of dental practice;
- the dependent practice of home health care services is classified under HP*.2.4.3 Community care centres.

HP.2.4 Outpatient care centres*

HP.2.4.1 Medical multi-specialist centres

74. This item comprises establishments engaged in providing a wide range of out-patient services by a team of medical, paramedical and often also support staff, usually bringing together several specialities and/or serving specific functions of primary care. These establishments generally treat patients who do not require in-patient treatment.

75. This item comprises establishments with physicians and other medical staff primarily engaged in providing surgical services (*e.g.* orthoscopic and cataract surgery) on an out-patient basis. Out-patient surgical establishments have specialised facilities, such as operating and recovery rooms, and specialised equipment, such as anaesthetic or X-ray equipment. Centres or clinics of health practitioners with different degrees from more than one speciality practising within the same establishment (*i.e.* physician and dentist) are included in this item.

76. *Note:* included are health maintenance organisation (HMO) medical centres and clinics. HMO type medical centres comprise establishments with physicians and other medical staff primarily engaged in providing a range of out-patient health care services to the HMO subscribers with a focus generally on primary health care. These establishments are owned by the HMO. Included are HMO establishments that both provide health care services and underwrite health and medical insurance policies. Included are integrated community care centres providing both in-patient and out-patient services primarily engaged in out-patient services.

Cross-references

- physician walk-in centres are classified under HP*.2.1.1 Offices of medical practitioners, HP*.2.1.2 Offices of medical specialists;
- hospitals that also perform ambulatory surgery and emergency room services are classified under HP*.1.1 General Hospitals
- multi-speciality out-patient polyclinics;
- multi-speciality HMO medical centres and clinics.
- centres and clinics of medical practitioners primarily engaged in the independent practice of their profession are classified under HP*.2.1.1 Offices of medical practitioners, HP*.2.1.2 Offices of medical specialists, and HP*.2.2 Offices of dentists;
- HMO establishments (other than those providing health care services) primarily engaged in underwriting health and medical insurance policies are classified under HP*.6 General health administration and insurance.

HP*.2.4.2 Dialysis care centres

77. This item comprises establishments with medical staff primarily engaged in providing out-patient kidney or renal dialysis services.

HP*.2.4.3 Community care centres

78. This item comprises establishments various types medical providers as family planning centers providing a range of family planning services on an out-patient basis, such as contraceptive services, genetic and prenatal counselling, voluntary sterilisation, and therapeutic and medically indicated termination of pregnancy.

Illustrative examples

- pregnancy counselling centres;
- birth control clinics;
- childbirth preparation classes;
- fertility clinics.
- out-patient alcoholism treatment centres and clinics (other than hospitals);
- out-patient drug addiction treatment centres and clinics (other than hospitals);
- out-patient mental health centres and clinics (other than hospitals);
- out-patient substance abuse treatment centres and clinics (other than hospitals).

To be further developed in detail:

HP*.2.5 Laboratories

79. This item comprises establishments primarily engaged in providing analytic or diagnostic services, including body fluid analysis and diagnostic imaging, generally to the medical profession or the patient on referral from a health practitioner.

Illustrative examples

- diagnostic imaging centres;
- dental or medical X-ray laboratories;

- medical testing laboratories;
- medical pathology laboratories⁴⁵;
- medical forensic laboratories.

Cross-references

80. Establishments, such as dental, optical, and orthopaedic laboratories, primarily engaged in providing the following activities to the medical profession, respectively: making dentures, artificial teeth, and orthodontic appliances to prescription; making lenses to prescription; and making orthopaedic or prosthetic appliances to prescription are classified under HP*.4 Retail sale and other providers of medical goods.

HP.2.6 Providers of preventive programs*

81. This item comprises government administration and provision of public health programmes such as health promotion and protection programmes. This item also comprises other establishments providing preventive care as *e.g.* occupational health care as ancillary production (see Annex 6.4 for the corresponding definitions and accounting rules).

Illustrative examples

- government provision and administration of public health programmes (as part of ISIC class 7512);
- public health department/district (USA: local health agency).

HP.3 Patient transportation*

HP.3.1 Ambulance services*

82. This item comprises establishments primarily engaged in providing transportation of patients by ground or air in the case of emergency. The vehicles are equipped with lifesaving equipment operated by medically trained personnel. In NACE Rev.2, ambulance services are recorded under 86.90 Other human health activities

83. *Note:* this item includes ambulance services provided in peacetime, non-disaster situations by the army, police or fire brigade.

HP.3.2 Other specialized transportation in health care*

84. This item comprises other establishments primarily engaged in providing specialized patient transport which is not rescue service along with health care.

Cross-references

85. Establishments primarily engaged in providing transportation of the disabled or elderly (without providing health care, such as taxi drivers) are classified under HP*.7.9 All other industries.

⁴⁵ In NACE Rev.2 establishments primarily engaged in collecting, storing and distributing blood and blood products are part of the pharmaceutical industry.

HP*.4 Retail sale and other providers of medical goods

86. This item comprises establishments whose primary activity is the retail sale of medical goods to the general public for personal or household consumption or utilisation. Establishments whose primary activity is the manufacture of medical goods for sale to the general public for personal or household use are also included as well as fitting and repair done in combination with sale. The possible link to NACE/ISIC depends very much on the national data structures as the NACE/ISIC does not provide enough detailed classification.

HP*.4.1 Dispensing chemists

87. This item comprises establishments primarily engaged in the retail sale of pharmaceuticals to the population for prescribed and non-prescribed medicines. Instances when the processing of medicine may be involved should be only incidental to selling. This includes both medicines with and without prescription.

Illustrative example

- public pharmacies.

Cross-references

- pharmacies in hospitals serving mainly out-patients are part of establishments classified under HP*.1 Hospitals and nursing care facilities;
- specialised dispensaries where the continuous monitoring of compliance and treatment plays an important role (such as for diabetes patients), are classified under

HP*.4.2 Retail sale and other suppliers of optical glasses and other vision products

88. This item comprises establishments primarily engaged in the retail sale of optical glasses and other vision products to the general public for personal or household consumption or utilisation. This includes the fitting and repair provided in combination with sales of optical glasses and other vision products. The item 4778 of NACE Rev.2 is more general.

HP*.4.3 Retail sale and other suppliers of hearing aids

89. This item comprises establishments primarily engaged in the sale of hearing aids to the general public for personal or household consumption or utilisation. This includes the fitting and repair provided in combination with the sale of hearing aids. The item 4774 of NACE Rev.2 is more general.

HP*.4.9 All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods

90. Other than optical goods and hearing aids to the general public with or without prescription for personal or household consumption or utilisation. Included are establishments primarily engaged in the manufacture of medical appliances but where the fitting and repair is usually done in combination with manufacture of medical appliances. This item comprises establishments engaged in the sale of other miscellaneous retail sale of medical goods to the general public for personal or household consumption or utilisation (included are sales other than by shops, such as electronic shopping and mail-order houses).

Illustrative examples

- sale of fluids (*e.g.* for home dialysis);
- all other miscellaneous health and personal care stores;

- all other sale of pharmaceuticals and medical goods;
- electronic shopping and mail-order houses specialised in medical goods.

91. It should be noted that pharmaceutical distribution by supermarkets, that are not separated in special retail units of pharmaceuticals is included in HP*.7 Other industries.

3.2 Households

HP*.5 Private households as providers of home health care

92. The boundary line drawn in the SHA includes personal services provided within households by family members, in cases where they correspond to social transfer payments granted for this purpose. This item, therefore, comprises private households as providers of home health care.

93. For national purposes countries might classify households in a more detailed way.

3.3 Health and financial administration

HP*.6 General health administration and insurance

94. This item comprises establishments primarily engaged in the regulation of activities of agencies that provide health care, overall administration of health policy, and health insurance.

95. *Note:* the role and definition of health insurance and other forms of financing health care are discussed in more detail in Chapters 9 and 10.

HP*.6.1 Government health administration

96. This item comprises government administration (excluding social security) primarily engaged in the formulation and administration of government policy in health and in the setting and enforcement of standards for medical and paramedical personnel and for hospitals, clinics, etc., including the regulation and licensing of providers of health services. This group of institutes covers also statistical institutes of ministry of health or institutes administering health registries. Health departments of regional or municipal governments should be included.

Illustrative examples

- Ministry of Health;
- Board of Health;
- Food and drug regulation agencies;
- Agencies for the regulation of safety on the workplace
- Institute of Health System Information and other institutes affiliated with Ministry of Health.

Cross-references

97. Government health agencies mainly engaged in providing public health services even if predominantly of a collective nature (surveillance, hygiene), are classified under HP*.2.6 Providers of preventive programmes.

HP.6.2 Social insurance funds*

98. This item comprises the funding and administration of government-provided social security programmes compensating for reduction of loss of income or inadequate earning capacity due to sickness (as part of ISIC 7530).

Illustrative examples

- administration of compulsory social health insurance and sickness funds;
- administration of compulsory employer's sickness funds;
- administration of compulsory social health insurance covering various groups of state employees (army, veterans, railroad and other public transport, police, state officials, etc.).

HP.6.3 Private insurance*

99. This item comprises insurance of health other than by social security funds and other social insurance (as part of ISIC class 6603). This includes establishments primarily engaged in activities involved in or closely related to the management of insurance (activities of insurance agents, average and loss adjusters, actuaries, and salvage administration; as part of ISIC class 6720).

100. This item comprises the funding and administration of private health insurance (other than government-provided compulsory social security programmes).

Illustrative examples

- administration of private health insurance funds;
- administration of complementary health insurance (e.g. mutualité);
- administration of employer's private health insurance programmes (other than government social security and government health programmes for state employees).

HP.6.4 Non-Profit-Institutions serving Households*

This item of non-profit institutions serving households (other than social insurance) typically brings together a range of heterogeneous institutions. An important role might be played by charities that provide health services for free (recorded under other current transfers, not as social benefits). They are financed by transfers from private households and enterprises, and might get additional funding from government and/or from the rest of the world. Only administration of the NPIsH have to be covered here.

HP.6.9 Other administrative units*

101. This item is important in complementary modules which for example with the administration of resources generation or generation of financial sources as medical savings accounts.

3.4 Other industries (Rest of the Economy)

102. This item comprises all other industries not providing health care as principal activity. To be further developed in detail.

HP*.7.1 Social Care providers

103. The breakdown of social care providers follows NACE Rev.2. This includes various types of establishments classified in NACE / ISIC 87 and 88 providing social care. Health care is not a dominant share of the output.

HP*.7.1.1 Residential mental retardation, mental health and substance abuse facilities

104. This item comprises establishments (*e.g.* group homes, hospitals, intermediate care facilities) primarily engaged in providing in an in-patient setting domiciliary services for persons diagnosed with mental retardation. These facilities may provide some health care, though the focus is on room and board, protective supervision, and counselling. Residential mental health and substance abuse facilities comprise establishments primarily engaged in providing residential care and treatment for patients with mental health and substance abuse illnesses. These establishments provide room, board, supervision, and counselling services. Although health care services may be available at these establishments, they are incidental to the counselling, mental rehabilitation, and support services offered. These establishments generally provide a wide range of social services in addition to counselling.

Illustrative examples

- alcoholism or drug addiction rehabilitation facilities (other than licensed hospitals);
- mental health halfway houses (USA);
- mental health convalescent homes or hospitals;
- residential group homes for the emotionally disturbed;
- MENCARE (Sweden).

Cross-references

- establishments primarily engaged in providing treatment of mental health and substance abuse illnesses on a predominantly out-patient basis are classified either under HP*.2.4.1 *Medical multi specialised care centres* or HP*.2.4.3 *Community care centres*;
- establishments known and licensed as hospitals primarily engaged in providing in-patient treatment of mental health and substance abuse illnesses with an emphasis on medical treatment and monitoring are classified under HP*.1.1.2, *Specialised hospitals*.

HP*.7.1.3 All other residential care facilities

105. This item comprises establishments primarily engaged in providing residential care (other than residential mental retardation, mental health, and substance abuse facilities and community care facilities for the elderly) often together with supervision and personal care services.

Illustrative examples

- group homes for the hearing or visually impaired;
- group homes for the disabled without nursing care.

Cross-references

- residential mental retardation facilities are classified under HP*.7.1.1 *Residential mental health care facilities*;
- continuing-care retirement communities and homes for the elderly without nursing are classified under HP*.7.1.2 *Residential facilities for the elderly / disabled*;

- establishments primarily engaged in providing in-patient nursing and rehabilitative services are classified under HP*.1.2.1 *Nursing care facilities*.

HP*.7.1.9 Other social care providers

106. This item comprises establishments primarily engaged in providing residential and personal care services for elderly and other persons (1) unable to fully care for themselves and/or (2) unwilling to live independently. Health and long-term care is not a dominant part of the output. The care typically includes room, board, supervision, and assistance in daily living, such as housekeeping services. In some instances these establishments provide skilled nursing care for residents in separate on-site facilities. Assisted living facilities with on-site nursing care facilities are included in this item, insofar not covered by Community care providers or nurses practitioners. Homes for the elderly without on-site nursing care facilities are also included.

Illustrative examples

- assisted-living facilities;
- continuing-care retirement communities;
- homes for the elderly without nursing care.

HP.7.2 Education and Training*

HP*.7.2.1 Medical education and training

107. This item includes education and training at any level or for medical professions. It includes education by the different academic institutions. Also included are military medical academies. The section includes public as well as private medical education. This group includes also general continuing education and continuing vocational education and training for medical professions.

HP*.7.2.2 Other education and training

108. This item includes education and training at any level or for other health professions, e.g. nurses.

HP.7.3 Research*

HP*.7.3.1 Scientific research

109. This item comprises basic clinical research, applied clinical research, experimental development in health sciences and engineering. It comprises experimental development on biotechnology, for example:

- DNA/RNA: genomics, pharmacogenomics, gene probes, genetic engineering, DNA/RNA sequencing/synthesis/ amplification, gene expression profiling, and use of antisense technology
- proteins and other molecules: sequencing/synthesis/engineering of proteins and peptides (including large molecule hormones); improved delivery methods for large molecule drugs; proteomics, protein isolation and purification, signalling, identification of cell receptors
- cell and tissue culture and engineering: cell/tissue culture, tissue engineering (including tissue scaffolds and biomedical engineering), cellular fusion, vaccine/immune stimulants, embryo manipulation

- process biotechnology techniques: fermentation using bioreactors, bioprocessing, bioleaching, biopulping, biobleaching, biodesulphurisation, bioremediation, biofiltration and phytoremediation
- gene and RNA vectors: gene therapy, viral vectors
- bioinformatics: construction of databases on genomes, protein sequences; modelling complex biological processes, including systems biology
- nanobiotechnology: applies the tools and processes of nano/microfabrication to build devices for studying biosystems and applications in drug delivery, diagnostics etc.

HP*.7.3.2 Market research

110. This item includes:

- investigation into health market development, acceptance and familiarity of goods and services and buying habits of consumers for the purpose of development of new goods and services, including statistical analyses of the results
- investigation into collective opinions of the public about political, economic and social issues and statistical analysis of the health system

HP*.7.4 Industries

HP*.7.4.1 Pharmaceutical Industry

111. This item includes manufacture of medicinal active substances to be used in the manufacture of medicaments and the manufacture of medicaments.

Illustrative examples

- manufacture of medicinal active substances to be used for their pharmacological properties in the manufacture of medicaments: antibiotics, basic vitamins, salicylic and O-acetylsalicylic acids etc.
- processing of blood
- manufacture of medicaments: antisera and other blood fractions, vaccines, diverse medicaments, including homeopathic preparations
- manufacture of chemical contraceptive products for external use and hormonal contraceptive medicaments
- manufacture of medical diagnostic preparations, including pregnancy tests
- manufacture of radioactive in-vivo diagnostic substances
- manufacture of biotech pharmaceuticals

This class also includes:

- manufacture of chemically pure sugars
- processing of glands and manufacture of extracts of glands etc.
- manufacture of medical impregnated wadding, gauze, bandages, dressings etc.
- preparation of botanical products (grinding, grading, milling) for pharmaceutical use

This class excludes:

- manufacture of herb infusions (mint, vervain, chamomile etc.), see NACE rev.2 10.83
- manufacture of dental fillings and dental cement, see NACE rev.2 32.50
- manufacture of bone reconstruction cements, see NACE rev.2 32.50
- manufacture of surgical drapes, see NACE rev.2 32.50
- wholesale of pharmaceuticals, see NACE rev.2 46.46
- retail sale of pharmaceuticals, see NACE rev.2 47.73
- research and development for pharmaceuticals and biotech pharmaceuticals, see NACE rev.2 72.1
- packaging of pharmaceuticals, see NACE rev.2 82.92

HP*.7.4.2 Manufacture of medical supplies

112. This item includes the manufacture of laboratory apparatus, surgical and medical instruments, surgical appliances and supplies, dental equipment and supplies. Included is the manufacture of medical, dental and similar furniture, where the additional specific functions determine the purpose of the product, such as dentist's chairs with built-in hydraulic functions.

Illustrative examples

- manufacture of surgical drapes and sterile string and tissue
- manufacture of dental fillings and cements (except denture adhesives), dental wax and other dental plaster preparations
- manufacture of bone reconstruction cements
- manufacture of dental laboratory furnaces
- manufacture of laboratory ultrasonic cleaning machinery
- manufacture of laboratory sterilisers
- manufacture of laboratory type distilling apparatus, laboratory centrifuges
- manufacture of medical, surgical, dental or veterinary furniture, such as: operating tables, examination tables, hospital beds with mechanical fittings, dentists' chairs
- manufacture of bone plates and screws, syringes, needles, catheters, cannulae, etc.
- manufacture of dental instruments (including dentists' chairs incorporating dental equipment)
- manufacture of artificial teeth, bridges, etc., made in dental labs
- manufacture of orthopedic and prosthetic devices
- manufacture of glass eyes
- manufacture of medical thermometers
- manufacture of ophthalmic goods, eyeglasses, sunglasses, lenses ground to prescription, contact lenses, safety goggles

This class excludes:

- manufacture of denture adhesives, see 20.42
- manufacture of medical impregnated wadding, dressings etc., see 21.20
- manufacture of electromedical and electrotherapeutic equipment, see 26.60
- manufacture of wheelchairs, see 30.92
- activities of opticians, see 47.78

HP*.7.4.3 Manufacture of denture

113. This item comprises special laboratories that manufacture dental fillings and cements (except denture adhesives), dental wax and other dental plaster preparations, orthodontic goods and orthodontic appliances.

HP*.7.4.5 Installation and repair of medical equipment

114. This item includes the specialised repair of goods produced in the manufacturing sector with the aim to restore medical equipment and other health products to working order. The provision of general or routine maintenance (*i.e.* servicing) on such products to ensure they work efficiently and to prevent breakdown and unnecessary repairs is included. This item does only include specialised repair and maintenance activities. A substantial amount of repair is also done by manufacturers of medical equipment and other health goods, in which case the classification of units engaged in these repair and manufacturing activities is done according to the value-added principle which would often assign these combined activities to the manufacture of the good. The same principle is applied for combined trade and repair.

HP*.7.5 Wholesale retailers

115. This unit does usually not deliver services directly to patients. Wholesalers frequently physically assemble, sort and grade goods in large lots, break bulk, repack and redistribute in smaller lots, for example pharmaceuticals; store, deliver and install goods, engage in sales promotion for their customers and label design.

HP*.7.6 Reinsurance

116. This item includes activities of assuming all or part of the risk associated with existing insurance policies originally underwritten by other insurance carriers. This item is particularly relevant in countries with private insurance (see NACE rev.2 65.20)

HP*.7.9 Others

117. This item comprises all other industries not elsewhere classified.

Illustrative examples

- occupational health care services not provided in separate health care establishments (all industries);
- Taxis.

HP*.9 Rest of the world

118. This item comprises all non-resident units providing health care for the final use by resident units.

4. REFERENCES

- Contandriopoulos, A.P., J.L. Denis, N. Touati and R. Rodriguez (2001), "Intégration des soins: dimensions et mise en œuvre", *Ruptures, Revue Transdisciplinaire en Santé*, vol. 8, pp. 38-52.
- Delnoij, Diana *et al.* (2002), "Integrated Care in an International Perspective", *International Journal of Integrated Care*, vol. 2, published online at www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1480379
- Eurostat (1995), *European System of Accounts, ESA 1995*, Eurostat, Luxembourg.
- Eurostat (2008), *NACE Rev.2 Statistical classification of economic activities in the European Community European System of Accounts*, Eurostat, Luxembourg.
- Hernandez, P., J-P. Poullier, and C. van Mosseveld, (2007), "Measuring Health Systems' Financing Flows", Paper presented at the Eurostat SHA Workshop in Tallinn, May 2007.
- Jeong, H.S. (2008), Proposals for the SHA classification: ICHAHP, *Input Document Unit 8*, Yonsei Institute for Health and Welfare, OECD, Eurostat, WHO: SHA-REV-08001.
- Liwendahl, C. and A. Skygge, (2008), Input paper to unit 8 "ICHA-HP classification of health care providers", Statistics Sweden, 2008-11-28.
- Mosseveld, C.J.P.M. van (2003), *International Comparison of Health Care Expenditure, Existing Frameworks, Innovations and Data Use*, Voorburg.
- Mosseveld, C.J.P.M. van (2009), Comments on Unit 9 and 10, OECD, Eurostat, WHO: SHA-Revision.
- National Board of Health (2008), Borderlines of the System of Health Accounts; Assistance with Implementation of System of Health Accounts (SHA) Organisation of Workshops, Eurostat Grant N° 35100.2006.012-2006.628.
- OECD (2000), *A System of Health Accounts*, OECD, Paris.
- OECD Health Division (2008a), Integration of the SNA Sequence of Accounts into SHA, Input Document Unit 5, Submitted on 11/09/2008, Document code SHA-REV-05005.
- OECD Health Division (2008b), A Proposal for the Main Categories of the Classification of Financing Schemes (ICHA-HF), Input Document Unit 10, Submitted on 17/07/2008, Document code SHA-REV-10001.
- OECD Health Division (2008c), Guidelines for the Delineation into Public and Private Units, OECD, Paris.
- ONS (2004), *SHA Guidelines: Practical guidance for implementing A System of Health Accounts in the EU*, Eurostat grant number: 200135100019, London.

Quintela, I. (2007), "Incorporating Input, Output and Productivity Measurements into the System of Health Accounts", paper presented at the 9th Meeting Of Health Accounts Experts And Correspondents For Health Expenditure Data, Paris, 8-9 October 2007, DELSA/HEA/HA(2007)5.

Pan American Health Organisation (2005), *Manual de Cuenta Satélite de Salud (CSS)*, Vers. 1.

Reich, U.-P. (2001), *National Accounts and Economic Value. A Study in Concepts*, Palgrave, London.

Roubal, T. (2008), Comment Various Units: Proposition of new dimensions into the new SHA, *SHA-revision document code 01103*, 28/11/2008

Schneider, M. (1995), "Framework for international comparison of health expenditure and financing, Discussion Paper January 1995", in *Statistics Netherlands, International Comparison of Health Data*, Voorburg/Herleen 1996, pp. 143-162.

Statistics Canada (2008), *North American Industry Classification (NAICS) 2007*, Statistics Canada, Ottawa.

United Nations, Eurostat, International Monetary Fund, Organisation for Economic Co-operation and Development, World Bank (1993), *A System of National Accounts 1993* (Brussels/Luxembourg, New York, Paris, Washington, D.C.).

United Nations (2005), *Government / Public Sector / Private Sector Delineation Issues*, AEG Meeting Task Force On Harmonisation Of Public Sector Accounting, 18 May 2005, Update of the 1993 SNA - Issue No. 36, Issues Paper For The July 2005.

United Nations (2008), International Standard Industrial Classification of All Economic Activities Revision 4, *Statistical papers Series M No. 4/Rev.4*, New York.

United Nations (2009), *System of National Accounts 2008*, Pre-edit version of Volume 2, New York.

Van Tongeren, J.W. (2006), "Review of OECD Health Accounts in Relation to SNA", Paper presented at the 8th Meeting Of Health Accounts Experts And Correspondents For Health Expenditure Data, Paris 5-6 October 2006, DELSA/HEA/HA(2006)6.

WHO (2003a): *Guide to producing national health accounts: with special applications for low-income and middle-income countries*, Geneva.

WHO (2003b): *The World Health Report 2003: Shaping the Future*, WHO, Geneva.

QUESTIONS

1. Do you agree that households form a special class at the 1st digit level (HP*.5)?
2. Do you agree to combine hospitals and nursing homes into one class of providers of inpatient care (HP*.1)?
3. Do you agree that offices of other health practitioners and providers of home health care services have been combined?
4. Under HP*.2.3 Other health care providers both health licensed practitioner (*i.e.* nurse practitioners) and non-allopathic practitioners (*i.e.* traditional healers) are combined. Do you want to separate licensed from non licensed providers?
5. Do you agree that providers of patient transportation are separated as a special class?
6. Do you agree to integrate “Provision and administration of public health programmes” into HP*.6 “Providers of health administration and financing” and with the special sub-class “Providers of preventive care” (HP*.2.6)?
7. Do you agree to split HP*.7 Other industries (rest of the economy) to make this part of the health care system more transparent?
8. Where should the distributors of pharmaceuticals (like supermarket) to be recorded under HP*.7.9 Others or HP*.4.9 Other retailers of medical goods?